

		FOR OHF USE					

LL 1

**2001**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF PUBLIC AID**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2001)**

IMPORTANT NOTICE  
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION  
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY  
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE  
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE  
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL  
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM  
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<b>I. IDPH Facility ID Number:</b> <u>0034066</u>		<b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b>	
<b>Facility Name:</b> <u>St Mary's Square Living Center</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>07/01/00</u> to <u>06/30/01</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
<b>Address:</b> <u>239 South Cherry Street</u> <u>Galesburg</u> <u>61401</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
<b>County:</b> <u>Knox</u>		<b>Officer or Administrator of Provider</b> (Signed) _____ (Date) _____ (Type or Print Name) <u>Bobby Dillard</u> (Title) <u>Administrator</u>	
<b>Telephone Number:</b> <u>(309) 343-4101</u> <b>Fax #</b> <u>(309) 343-4118</u>		<b>Paid Preparer</b> (Signed) <u>See Accountant's Report</u> _____ (Date) _____ (Print Name and Title) <u>McGladrey &amp; Pullen, LLP</u> <u>117 East Main Street, Suite 210</u> (Firm Name & Address) <u>P.O. Box 1070</u> <u>Galesburg, IL 61401</u> (Telephone) <u>(309) 342-1175</u> <b>Fax #</b> <u>(309) 342-7816</u>	
<b>IDPA ID Number:</b> <u>37-1223609001</u>		<b>MAIL TO: OFFICE OF HEALTH FINANCE</b> <b>ILLINOIS DEPARTMENT OF PUBLIC AID</b> 201 S. Grand Avenue East Springfield, IL 62763-0001 <b>Phone #</b> (217) 782-1630	
<b>Date of Initial License for Current Owners:</b> <u>07/15/88</u>			
<b>Type of Ownership:</b>			
<input checked="" type="checkbox"/> <b>VOLUNTARY, NON-PROFIT</b>			
<input checked="" type="checkbox"/> Charitable Corp.			
<input type="checkbox"/> Trust			
<b>IRS Exemption Code</b> <u>501(c)(3)</u>			
<input type="checkbox"/> <b>PROPRIETARY</b>			
<input type="checkbox"/> Individual			
<input type="checkbox"/> Partnership			
<input type="checkbox"/> Corporation			
<input type="checkbox"/> "Sub-S" Corp.			
<input type="checkbox"/> Limited Liability Co.			
<input type="checkbox"/> Trust			
<input type="checkbox"/> Other _____			
<input type="checkbox"/> <b>GOVERNMENTAL</b>			
<input type="checkbox"/> State			
<input type="checkbox"/> County			
<input type="checkbox"/> Other _____			
<b>In the event there are further questions about this report, please contact:</b> <b>Name:</b> <u>Ron Wilson</u> <b>Telephone Number:</b> <u>(309) 343-1550</u>			

SEE ACCOUNTANTS' COMPILATION REPORT

## STATE OF ILLINOIS

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Facility Name & ID Number St Mary's Square Living Center# 0034066 Report Period Beginning: 07/01/00 Ending: 06/30/01

## III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,  
(must agree with license). Date of change in licensed bedsN/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	<u>255</u>	Intermediate/DD	<u>255</u>	<u>93,075</u>	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>255</u>	TOTALS	<u>255</u>	<u>93,075</u>	7

## B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	<u>74,855</u>	<u>365</u>		<u>75,220</u>	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>74,855</u>	<u>365</u>		<u>75,220</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4.) 80.82%

D. How many bed-hold days during this year were paid by Public Aid?

995 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.  
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or  
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 04/01/80

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 07/15/88 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☐ NO ☒ If YES, enter number  
of beds certified \_\_\_\_\_ and days of care provided N/AMedicare Intermediary N/A

## IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH\* ☐ CASH\* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 06/30/01 Fiscal Year: 06/30/01

\* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

## STATE OF ILLINOIS

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Facility Name &amp; ID Number

St Mary's Square Living Center

# 0034066

Report Period Beginning:

07/01/00

Ending:

06/30/01

## V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>A. General Services</b>											
1	Dietary	362,152	23,481	13,200	398,833		398,833		398,833			1
2	Food Purchase		299,933		299,933	(8,531)	291,402		291,402			2
3	Housekeeping	297,553	32,436		329,989		329,989		329,989			3
4	Laundry	130,383	27,382		157,765		157,765		157,765			4
5	Heat and Other Utilities			241,186	241,186		241,186		241,186			5
6	Maintenance	112,097	109,034	77,889	299,020		299,020		299,020			6
7	Other (specify):*											7
8	<b>TOTAL General Services</b>	902,185	492,266	332,275	1,726,726	(8,531)	1,718,195		1,718,195			8
	<b>B. Health Care and Programs</b>											
9	Medical Director			17,200	17,200		17,200		17,200			9
10	Nursing and Medical Records	2,556,413	85,089	21,470	2,662,972		2,662,972		2,662,972			10
10a	Therapy			14,760	14,760		14,760		14,760			10a
11	Activities	69,224	44,634	8,488	122,346		122,346	(41,096)	81,250			11
12	Social Services	42,929		1,060	43,989		43,989		43,989			12
13	Nurse Aide Training	8,902			8,902		8,902		8,902			13
14	Program Transportation			129	129	5,172	5,301		5,301			14
15	Other (specify):*											15
16	<b>TOTAL Health Care and Programs</b>	2,677,468	129,723	63,107	2,870,298	5,172	2,875,470	(41,096)	2,834,374			16
	<b>C. General Administration</b>											
17	Administrative	114,950			114,950		114,950		114,950			17
18	Directors Fees			7,109	7,109		7,109	(4,116)	2,993			18
19	Professional Services			355,958	355,958		355,958		355,958			19
20	Dues, Fees, Subscriptions & Promotions			27,584	27,584		27,584	(4,101)	23,483			20
21	Clerical & General Office Expenses	96,289	35,215	13,656	145,160		145,160		145,160			21
22	Employee Benefits & Payroll Taxes			734,569	734,569	8,531	743,100		743,100			22
23	Inservice Training & Education			1,678	1,678		1,678		1,678			23
24	Travel and Seminar			10,852	10,852		10,852	(7,717)	3,135			24
25	Other Admin. Staff Transportation			10,343	10,343	(5,172)	5,171		5,171			25
26	Insurance-Prop.Liab.Malpractice			83,262	83,262		83,262		83,262			26
27	Other (specify):* <b>Bad Debt/Donations</b>			27,681	27,681		27,681	(27,681)				27
28	<b>TOTAL General Administration</b>	211,239	35,215	1,272,692	1,519,146	3,359	1,522,505	(43,615)	1,478,890			28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	3,790,892	657,204	1,668,074	6,116,170		6,116,170	(84,711)	6,031,459			29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

## STATE OF ILLINOIS

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Facility Name &amp; ID Number

St Mary's Square Living Center

#0034066

Report Period Beginning:

07/01/00

Ending:

06/30/01

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			69,259	69,259		69,259		69,259			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			115,931	115,931		115,931		115,931			33
34	Rent-Facility & Grounds			543,600	543,600		543,600		543,600			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			728,790	728,790		728,790		728,790			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			447,992	447,992		447,992		447,992			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			447,992	447,992		447,992		447,992			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,790,892	657,204	2,844,856	7,292,952		7,292,952	(84,711)	7,208,241			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number St Mary's Square Living Center

# 0034066

Report Period Beginning: 07/01/00

Ending: 06/30/01

## VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(11,111)	V-27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(16,570)	V-27		24
25	Fund Raising, Advertising and Promotional	(4,101)	V-20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Attached	(52,929)	Var		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (84,711)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B) )	\$ (84,711)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

## St Mary's Square Living Center

ID# 0034066

Report Period Beginning: 07/01/00

Ending: 06/30/01

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

## Summary A

06/30/01

06/30/01

[illegible]

## Summary B

**SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I**

[illegible]



**VII. RELATED PARTIES**

**A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
None		None		None		

**B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.** ☐ YES ☒ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger	4 Amount	5 Cost to Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
			Item		Name of Related Organization				
1	V			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

## STATE OF ILLINOIS

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Facility Name & ID Number St Mary's Square Living Center # 0034066 Report Period Beginning: 07/01/00 Ending: 06/30/01

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Shard Hansen	President	Director	None	N/A	N/A	N/A	Board Mtgs	\$ 1,200	18-3	1
2	Stanley Sidlowsky, D.D.S.	Director	Director	None	N/A	N/A	N/A	Board Mtgs	0	18-3	2
3	Ken Morss	Director	Director	None	N/A	N/A	N/A	Board Mtgs	300	18-3	3
4	Charles D. Westbay	Secretary/Treasurer	Director	None	N/A	N/A	N/A	Board Mtgs	1,200	18-3	4
5	Gary Bruington	Director	Director	None	N/A	N/A	N/A	Board Mtgs	0	18-3	5
6											6
7											7
8											8
9					Training & meeting expense				4,409	18-3	9
10					Less: Non-allowable out-of-state training				(4,116)	18-7	10
11											11
12											12
13								TOTAL	\$ 2,993		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).  
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME.  
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Mary's Square Living Center # 0034066 Report Period Beginning: 07/01/00 Ending: 06/30/01

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1							\$					\$	1
2	None												2
3													3
4													4
5													5
	Working Capital												
6													6
7													7
8													8
9	TOTAL Facility Related						\$		\$			\$	9
	B. Non-Facility Related*												
10													10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$		\$			\$	14
15	TOTALS (line 9+line14)						\$		\$			\$	15

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

## B. Real Estate Taxes

**NOTES:**

1. Please indicate a negative number by use of brackets ( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

**SEE ACCOUNTANTS' COMPILATION REPORT**

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates    **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Office of Health Finance at (217) 782-1630.

**2000 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME    St Mary's Square Living Center    COUNTY    Knox

FACILITY IDPH LICENSE NUMBER    0034066

CONTACT PERSON REGARDING THIS REPORT    Ron Wilson

TELEPHONE    (309) 343-1550    FAX #:    (309) 343-2857

**A.    Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>9915233010</u>	<u>239 S. Cherry Galesburg, IL</u>	\$ <u>108,145.16</u>	\$ <u>108,145.00</u>
2. <u>9915233008</u>	<u>239 S. Cherry Galesburg, IL</u>	\$ <u>489.94</u>	\$ <u>490.00</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u><u>108,635.10</u></u>	\$ <u><u>108,635.00</u></u>

**B.    Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?           YES      X   NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C.    Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

A. Square Feet: 131,912

B. General Construction Type: Exterior Brick Frame Wood Number of Stories 4 and 5

C. Does the Operating Entity? ☐ (a) Own the Facility ☐ (b) Rent from a Related Organization. ☒ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☒ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ NO

If so, please complete the following:

1. Total Amount Incurred: N/A

2. Number of Years Over Which it is Being Amortized: N/A

3. Current Period Amortization: N/A

4. Dates Incurred: N/A

Nature of Costs: N/A

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>N/A-Facility Leased</u>			\$	1
2					2
3	TOTALS			\$	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number St Mary's Square Living Center

# 0034066

Report Period Beginning:

07/01/00

Ending:

06/30/01

**XL OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	255			\$	\$		\$	\$	\$
5	Facility								
6	Leased								
7									
8									
<b>Improvement Type**</b>									
9	Garage addition, Sidewalk, Furnace, Elevator	1988		46,740	2,906	15-20	2,906		40,438
10	Sprinkler, Roof repair	1989		29,422	1,455	20-25	1,455		16,967
11	Water Chiller repair, Boiler repair	1990		11,633	641	15-20	641		7,166
12	Roof repair, Roofing	1991		49,477	2,474	20	2,474		25,642
13	Heater/furnace	1992		2,505	167	15	167		1,447
14	Windows, Sidewalk	1993		7,150	476	15	476		3,846
15	Paving, Plumbing, Boiler Equipment, Roofing	1994		30,695	2,035	10-20	2,035		14,073
16	A/C Chiller, Tuck point, Roofing, Transformer, Elevator Equip, Sewer	1995		102,052	4,771	15-25	4,771		27,099
17	Alarm electric work, Water heater, Door closers, A/C Units, Stucco Work	1996		62,518	4,112	10-25	4,112		20,396
18	A/C Units	1997		7,776	518	15	518		2,288
19	Fire Alarm System	1997		5,718	572	10	572		2,050
20	Paving	1997		49,475	6,184	8	6,184		22,159
21	Fire Alarm	1998		6,762	676	10	676		2,197
22	Paving	1998		6,174	772	8	772		2,445
23	Condensate Ret. System	1998		3,404	227	15	227		605
24	Coils & Stats	1999		5,688	569	10	569		1,185
25	Fire Alarm System	1999		24,710	2,471	10	2,471		4,942
26	Fire Alarm System	1999		15,794	1,579	10	1,579		2,632
27	Commercial Door	1999		4,000	267	15	267		445
28	Fire Alarm System	1999		12,154	1,215	10	1,215		1,924
29	Kitchen Upgrade	2000		11,777	785	15	785		916
30	Air Conditioner Rep	2000		5,000	333	15	333		389
31	Counter Top	2000		2,390	159	15	159		172
32	Air Conditioner Rep	2000		2,500	167	15	167		167
33	Hall Handle Repairs	2000		1,860	171	10	171		171
34	HVAC Repairs	2000		7,020	585	10	585		585
35									
36									

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT



**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 514,394	\$ 36,287		\$ 36,287	\$	\$ 202,346	70

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 401,265	\$ 27,804	\$ 27,804	\$	5-15 yrs	\$ 277,785	71
72	Current Year Purchases	32,403	1,235	1,235		5-15 yrs	1,235	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 433,668	\$ 29,039	\$ 29,039	\$		\$ 279,020	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	See Attached Schedule I	See Attached Schedule I	See Attached Schedule I	\$ 183,061	\$ 3,933	\$ 3,933	\$		\$ 170,080	76
77										77
78										78
79										79
80	TOTALS			\$ 183,061	\$ 3,933	\$ 3,933	\$		\$ 170,080	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,131,123	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 69,259	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 69,259	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 651,446	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

## XII. RENTAL COSTS

### A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Wells Fargo Bank Illinois, as under provision of Trust # Y3444

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☒ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	<u>1985</u>	<u>255</u>	<u>10/10/00</u>	\$ <u>543,600</u>	<u>15</u>	<u>None</u>	3
4	Additions							4
5								5
6								6
7	TOTAL		<u>255</u>		\$ <u>543,600</u>			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease N/A.

None

N/A

9. Option to Buy: ☐ YES ☒ NO Terms: N/A \*

### B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☒ YES ☐ NO

16. Rental Amount for movable equipment: \$ N/A Description: Amount not determined.

(Attach a schedule detailing the breakdown of movable equipment)

### C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning 12/01/2000

Ending 11/30/2015

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. 6/30/2002 \$ 543,600

13. 6/30/2003 \$ 543,600

14. 6/30/2004 \$ 543,600

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

**A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)**

<b>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</b>  <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	<b>2. CLASSROOM PORTION:</b>  IN-HOUSE PROGRAM <input checked="" type="checkbox"/>  IN OTHER FACILITY <input type="checkbox"/>  COMMUNITY COLLEGE <input type="checkbox"/>  HOURS PER AIDE <u>40</u>	<b>3. CLINICAL PORTION:</b>  IN-HOUSE PROGRAM <input checked="" type="checkbox"/>  IN OTHER FACILITY <input type="checkbox"/>  HOURS PER AIDE <u>40</u>
---	--	---

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)		8,902		8,902
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	8,902	\$	8,902
10	SUM OF line 9, col. 1 and 2 (e)	\$	8,902		

**C. CONTRACTUAL INCOME**

In the box below record the amount of income your facility received training aides from other facilities.

\$ None

**D. NUMBER OF AIDES TRAINED**

<b>COMPLETED</b>	
1. From this facility	35
2. From other facilities (f)	
<b>DROP-OUTS</b>	
1. From this facility	
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	<b>35</b>

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.  
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.  
 (c) For in-house training programs only. Do not include fringe benefits.  
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.  
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.  
**SEE ACCOUNTANTS' COMPILATION REPORT**

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 538,884	\$	1
2	Cash-Patient Deposits	12,957		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 100,000 )	735,427		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments	875,583		5
6	Prepaid Insurance	73,807		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Interdivision Receivables</u>	4,866,561		9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 7,103,219	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	3,820,746		12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	514,394		15
16	Equipment, at Historical Cost	616,729		16
17	Accumulated Depreciation (book methods)	(651,446)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Leasehold deposit</u>	132,500		23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 4,432,923	\$	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 11,536,142	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 158,775	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	12,957		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	212,650		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	111,746		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36				36
37	<u>Operating Advances</u>	1,000,000		37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 1,496,128	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$	\$	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 1,496,128	\$	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 10,040,014	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 11,536,142	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	<b>\$ 9,171,908</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<u>Change to accrual method for vacation expense</u>	<u>(67,526)</u>	<b>3</b>
<b>4</b>	<u>Set up allowance for doubtful accounts</u>	<u>(88,770)</u>	<b>4</b>
<b>5</b>	<u>BMQA audit adjustments to prior years</u>	<u>(26,448)</u>	<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	<b>\$ 8,989,164</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>881,812</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe) <u>Unrealized gain on investments</u>	<u>169,038</u>	<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	<b>\$ 1,050,850</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	<b>\$</b>	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	<b>\$ 10,040,014</b>	<b>24 *</b>

\* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.  
**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 7,726,006	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 7,726,006	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	8,902	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 8,902	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	394,416	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 394,416	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>Activity Fund Income</b>	41,096	28
28a	<b>Gain on Sale of Vehicle</b>	4,344	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 45,440	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 8,174,764	30

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	1,726,726	31
32	Health Care	2,870,298	32
33	General Administration	1,519,146	33
	<b>B. Capital Expense</b>		
34	Ownership	728,790	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers		35
36	Provider Participation Fee	447,992	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 7,292,952	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	881,812	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 881,812	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? N/A If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.



## STATE OF ILLINOIS

Page 20

Facility Name & ID Number St Mary's Square Living Center# 0034066Report Period Beginning: 07/01/00Ending: 06/30/01

## XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	3,364	3,472	\$ 63,859	\$ 18.39	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses	26,055	30,510	397,034	13.01	4
5	Nurse Aides & Orderlies	165,553	186,587	1,638,058	8.78	5
6	Nurse Aide Trainees	1,171	1,171	8,902	7.60	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	5,564	6,226	69,224	11.12	9
10	Activity Assistants					10
11	Social Service Workers	5,143	5,612	42,929	7.65	11
12	Dietician					12
13	Food Service Supervisor	1,912	2,080	36,283	17.44	13
14	Head Cook					14
15	Cook Helpers/Assistants	32,685	36,738	325,869	8.87	15
16	Dishwashers					16
17	Maintenance Workers	8,732	9,367	112,097	11.97	17
18	Housekeepers	27,377	30,757	297,553	9.67	18
19	Laundry	13,239	14,675	130,383	8.88	19
20	Administrator	2,005	2,080	75,884	36.48	20
21	Assistant Administrator					21
22	Other Administrative	1,951	2,076	39,066	18.82	22
23	Office Manager					23
24	Clerical	10,212	11,459	96,289	8.40	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	32,502	34,594	402,289	11.63	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,793	4,415	55,173	12.50	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	341,258	381,819	\$ 3,790,892 *	\$ 9.93	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

## B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	***	\$ 13,200	1-3	35
36	Medical Director	***	17,200	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	***	7,200	10-3	39
40	Physical Therapy Consultant	***	1,095	10-3A	40
41	Occupational Therapy Consultant	***	4,455	10-3A	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	***	9,210	10-3A	43
44	Activity Consultant				44
45	Social Service Consultant	***	1,060	12-3	45
46	Other(specify) <u>Dental Consultant</u>	***	4,850	10-3	46
47	<u>Psychological Consultant</u>	***	9,420	10-3	47
48	<u>*** = Monthly Fee Arrangement</u>				48
49	TOTAL (lines 35 - 48)		\$ 67,690		49

## C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	\$		50
51	Licensed Practical Nurses			51
52	Nurse Aides			52
53	TOTAL (lines 50 - 52)	\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

## **XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions			
Name	Function	Ownership %	Amount	Description		Amount	Description		Amount		
Bobby Dillard	Administrator	None	\$ 75,884	Workers' Compensation Insurance		\$ 153,001	IDPH License Fee		\$ 200		
Robert Johnston	HR Director	None	27,645	Unemployment Compensation Insurance		2,972	Advertising: Employee Recruitment		13,799		
Jerry DuBois	Asst. Admin.	None	11,421	FICA Taxes		287,363	Health Care Worker Background Check (Indicate # of checks performed 175 )		2,098		
				Employee Health Insurance		240,364	Subscriptions, dues and fees		6,496		
				Employee Meals		8,531	Advertising-Promotion		4,101		
				Illinois Municipal Retirement Fund (IMRF)*			Other licenses and fees		890		
				Other Employee Benefits		14,868					
				401 (k) Plan Contributions		36,001					
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)											
\$ 114,950											
B. Administrative - Other											
Description			Amount								
			\$								
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)											
\$				TOTAL (agree to Schedule V, line 22, col.8)				\$ 743,100			
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**			
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description		Amount		
RFMS, Inc.	Administrative Services		\$ 254,100			\$	Out-of-State Travel		\$		
McGladrey & Pullen, LLP	Accounting Services		15,310								
Community Living Options	Support Services		86,460								
Hattery, Simpson & West	Legal Fees		88				In-State Travel				
							Staff use of personal vehicle on facility business and meals (under \$250 per travel voucher)		11		
							Seminar Expense		10,841		
							Less: Non-allowable seminar expense		(7,717)		
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)				TOTAL				Entertainment Expense (			
\$ 355,958				\$				(agree to Sch. V, line 24, col. 8)			
								TOTAL \$ 3,135			

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT

**\*\*See instructions.**

**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS** (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2	None												
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Mary's Square Living Center

STATE OF ILLINOIS

# 0034066

Report Period Beginning:

07/01/00

Ending:

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06/30/01

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No  
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 12 yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 26,446 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 447,992  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 8,531 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? None  
d. Have vehicle usage logs been maintained? Yes  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes  
g. Does the facility transport residents to and from day training? No  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.